

PSYCHIATRIC ILLNESS IN HUNGARIAN REFUGEES

By

A. G. MEZEY, M.D., M.Sc., M.R.C.P.E., D.P.M.

Institute of Psychiatry, Maudsley Hospital, London, S.E.5

At the beginning of this century the high rate of "insanity" among immigrants was a matter of considerable concern in the U.S.A. and it has been used as one of the main arguments for curtailing immigration. The problem has been reviewed, and examined with modern statistical methods, by Ødegaard (1932) and Malzberg (1940).

It has been estimated that forty million people have become refugees since 1945 (E. Rees, 1957), and this has generated a renewed interest in this tragically topical problem. Considerable attention has been focused on the plight of Hungarian refugees (Hoff and Strotzka, 1958; Koranyi, Kerenyi and Sarwer-Foner, 1958; *The Hungarian Revolution of October 1956*, 1958), who have recently joined the millions of international migrants.

Between November 1956 and April 1957 about twenty thousand Hungarians were admitted into the United Kingdom (*Refugees in England*, 1958), and the medical problems arising from such massive arrival of refugees have been described by Dormandy, Eldon and Milner (1957). Previous papers (Frost, 1938; Kino, 1951; Murphy, 1955) have examined certain clinical and statistical aspects of psychiatric illness among immigrants admitted to mental hospitals in England, but Murphy (1952) has regretted the total absence of studies of neurosis in any refugee group in Britain. In addition, the refugees and displaced persons who have been the subjects of these studies came from diverse cultural backgrounds, have often lived for years in concentration camps with their attendant physical and psychological traumata, and have spent widely differing periods of time in this country before illness led to hospital admission. The Hungarian patients, on the other hand, were rather suddenly immersed from one cultural environment into another and it was possible to examine a relatively large number of cases of all forms and degrees of severity, breaking down in the first two years following their emigration. We propose to describe the clinical findings in this group of patients; the relationship of the personal background to the form of their subsequent illness will be discussed elsewhere (Mezey, 1960).

CASE MATERIAL

It became obvious soon after the arrival of Hungarian refugees in the United Kingdom that the psychiatric care of those needing it was made particularly difficult by the language barrier. To deal with these cases, at the request of the Hungarian section of the British Council for Aid to Refugees, (B.C.A.R.), a temporary clinic conducted by an Hungarian-speaking psychiatrist was established at the Maudsley Hospital.

The data regarding the composition of the group of Hungarian patients here reviewed are summarized in Table I.

In a proportion of cases, the patient was initially seen by a psychiatric social worker employed by the B.C.A.R., and then by the writer at the

TABLE I

Distribution of patients with regard to mode of arrival to the U.K., referral for psychiatric care, residence on referral, source of information, religion, marital status and social class.

Mode of arrival to the U.K.	Bulk schemes for refugees	..	..	65
	Mining recruits	..	..	12
	Individual visas	..	..	5
Referred by	Voluntary and Governmental agencies	..	..	31
	General Practitioners	..	..	23
	Hospitals	..	..	21
	Patient (or his family)	..	..	7
Residence on Referral	London	..	..	62
	Elsewhere in England	..	..	20
Independent Information	Satisfactory	..	..	21
	Adequate	..	..	44
	Poor (or none)	..	..	17
Religion	Roman Catholic	..	..	52
	Protestant	..	..	14
	Jewish	..	..	13
	Other	..	..	3
Marital Status	Single	..	..	42
	Married	..	..	18
	Widowed	..	..	4
	Divorced or separated	..	..	18
Education	None	..	..	1
	Elementary	..	..	50
	Secondary	..	..	17
	Academic	..	..	14
Social Class (in Hungary)	Professional	..	..	4
	Intermediate and artisanal	..	..	46
	Labouring	..	..	32
Social Class (In England)	Professional	..	..	1
	Intermediate and artisanal	..	..	29
	Labouring	..	..	52

Maudsley Hospital. During the initial period, when the B.C.A.R. was in charge of the resettlement of Hungarian refugees, practically every case came through their intermediary, but later an increasing number were referred by other agencies, voluntary (e.g. denominational) or official (National Assistance Board, Prison Commission, etc.). As the refugees were leaving the hostels to settle in the community, they started to come mainly through medical channels. There were also a few instances of self-referral.

During the two-year period from 1 February, 1957, to 31 January, 1959, altogether 90 cases have been seen at this special clinic at the Maudsley Hospital. Of these, eight cases were excluded for the following reasons: in four the information obtained was insufficient (emergency cases or lack of co-operation), two were immigrants of a previous period and did not qualify for inclusion, and in two no psychiatric abnormality was found.

The present report is therefore based on observations in 82 consecutive cases of recently arrived Hungarian refugees with psychiatric disorders. These patients all arrived in England between November 1956 and April 1957. Nearly eighty per cent of them came under bulk schemes organized by the B.C.A.R., and the rest as mining recruits engaged by the National Coal Board or with individual visas.

This was the only clinic dealing specifically with this population and

therefore the majority, if not the totality, of psychiatric problems among Hungarian refugees in the metropolitan area were referred to it. Nearly a quarter of cases, however, were referred from areas as far distant as Bristol and Fleetwood.

The age and sex distribution of patients is given in a histogram (Fig. 1). An age check of a random sample of Hungarian refugees taken from the Home Office Register (*Refugees in Britain*, 1958) showed that 84 per cent. of Hungarian refugees were between the ages of 18 and 40, as compared to only 65 per cent. in our sample. One-quarter of our group were females, males heavily outnumbering females in the 16-24 age group. The proportion of women in the Hungarian refugee population admitted to Britain is not known.

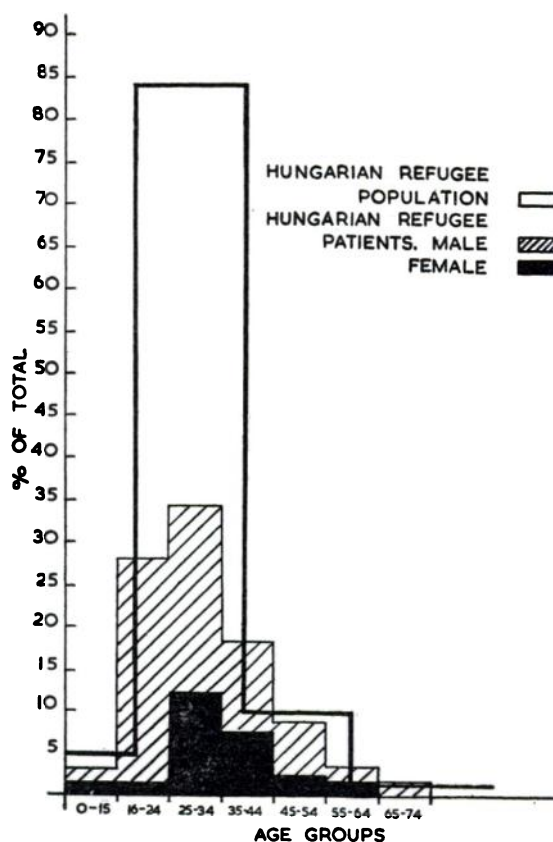


FIG. 1.—Age and sex distribution of Hungarian psychiatric patients, compared with the age distribution of a random sample of Hungarian refugees (*Refugees in Britain*, 1958).

For the proper evaluation of the history, it seemed important to supplement the information received from the patient by contacting his relatives, acquaintances and (in the case of previous psychiatric illness) hospitals, whether in England or in Hungary. Only in a quarter of the cases was it possible to have a complete history from independent sources; in more than half the information obtained from sources other than the patient himself covered the most important areas (personal relationships, previous illnesses

and present symptoms) and only in about 20 per cent was outside information absent or very inadequate.

The majority of patients seen (60.3 per cent.) were, as expected, of the Roman Catholic faith and the remainder distributed among other denominations. Men greatly outnumbered women in all but the Jewish group (six men to seven women).

This was a predominantly young population and just over half of the patients were single. It is striking, however, that the number of divorced or separated patients equalled that of married people. Relevant data for Hungary, or for the total Hungarian refugee population in Britain are not available.

One patient of gipsy extraction (struck by severe paralytic poliomyelitis in early childhood) never had any sort of schooling; the majority partook of the compulsory elementary education until the age of 13.

About 30 per cent. of patients went to secondary school, and 17 per cent. had some form of superior education, not always completed. More than half of the patients were merchants, white collar or skilled workers in Hungary; a considerable proportion were labourers and less than 5 per cent. belonged to the professions. A frequent downgrading in social class was observed as characteristic of their occupational status in Britain.

HISTORY

The circumstances of the investigation were such that reliable information on the incidence (and nature) of *psychiatric illness in parents* and collaterals could not be expected, but the impression was that this was not unduly high.

There was a history of *previous mental illness* in half of our patients (Certain in 30, Probable or Possible in 11). To be classed in the Certain category, a patient had to have a history of admission to a mental hospital in Hungary, or of being treated as an outpatient for a disorder diagnosed as psychiatric. Previous psychiatric illness was considered Probable if the patient had a history of temporarily incapacitating disorder and either this was regarded by his medical attendants as possibly psychiatric or "nervous", or the mental and somatic symptoms of the previous illness were practically identical, in the view of the patient or other informants, to those for which he was referred in England. The criteria for Possible psychiatric illness were similar, but in these cases the information at disposal was usually less complete or reliable.

Mrs. I.S., *aet.* 43. Referred from another hospital, where after pulmonary resection for tuberculosis, she developed florid ideas of significance and of reference, irritability and violent fluctuations of mood. Since the age of 12 she had been subject to periods of incapacitating mental illness, each of a few months' duration; in the earlier attacks mostly anxiety and its somatic concomitants, later fatigue, depression, paranoid delusions and marked agitation. Since the age of 30 admitted on at least three occasions to mental hospitals, for periods up to ten months. Treated with deep insulin, repeated courses of electro-shock and drugs. Considered unfit for work during last three years. Previous psychiatric illness Certain.

Mr. J.M., *aet.* 32, hairdresser. Complains of severe headaches, pressure in throat, palpitations, pain behind the eyes. Extensively investigated in two London teaching hospitals, along somatic lines. N.A.D. and referred for psychiatric opinion.

First similar illness in 1954. Investigated in Budapest where all findings, including B.M.R., were within normal limits. In view of the subjective respiratory difficulties, the diagnosis of retro-sternal goitre was made and thyroidectomy performed. Subsequent periodic recurrence of same symptoms. Previous psychiatric illness Probable.

Mr. G.F., *aet.* 30, civil engineer. Referred by his employer for abnormal behaviour at work. Believes he is suspected of being a Communist spy, he is followed in the streets,

his room is searched in his absence, his colleagues are jealous because of his promotion and make subtly disparaging remarks, etc.

Two previous illnesses, in 1952 and 1954, of indefinite character. Morose, uncommunicative, irritable and unable to work for several weeks. Refused to see a psychiatrist, or indeed any doctor, although advised to do so. Previous psychiatric illness Possible.

The *onset* of the present illness was acute (duration less than three months) in 38 cases, subacute (duration on referral between four and twelve months) in 25 cases, and chronic (duration over one year) in 19 cases.

CLINICAL FINDINGS

The *leading symptom* (Table II) was most often physical, either in the sense of the somatic manifestations of anxiety and depression or a hysterical

TABLE II

Distribution of the leading symptoms in Hungarian psychiatric patients

Somatic complaints	23
Abnormal behaviour	22
Delusion	12
Suicidal attempt	9
Disorder of function	5
Fear and/or depression	3
Antisocial act	3
Social incompetence	3
Disorder of consciousness	2

disorder of function. Tyhurst (1951) has made similar observations in displaced persons settling in Canada. In view of the difficulty in communicating with these patients, it is not surprising that they were often subjected to manifold clinical, laboratory and radiological investigations before the psychiatric nature of the illness was suspected.

Abnormal behaviour was the next most common presenting symptom; this took a variety of forms, from aggressive outbursts to wandering, and from suicidal threats to smearing of faeces on lavatory seats. In the majority of schizophrenics the presenting symptom was delusional, sometimes inseparable from hallucinatory experiences. A suicidal attempt of variable severity, and sometimes repeated, was the leading symptom in nine cases.

Rarely, and only in patients who have previously been under psychiatric treatment, was the initial symptom expressed in psychological terms such as anxiety or depression. A small number of cases were referred for antisocial acts (one after homicide, two for stealing). In three cases the immediate reason for referral was the inability to obtain or hold employment. Finally, two patients came for intermittent disorder of consciousness (a dissociative state and a case of traumatic epilepsy).

The distribution of patients according to *diagnosis* is given in Table III. We have used four main diagnostic categories; the subdivisions within these were inevitably arbitrary and the designations meant to indicate the clinical form of the illness when observed, rather than to describe an independent entity.

The most frequent form of schizophrenia was the paranoid. In many cases the delusional ideas were bearing the mark of recent experiences and of the present life situation of the patient: feeling accused of being a Communist spy, or being persecuted by ubiquitous Communist agents. Hallucinated voices, when reported, were often said to speak in English and in these cases the patient had no doubt about their derogatory meaning, although they were

TABLE III

Distribution of Hungarian psychiatric patients according to diagnosis

<i>Schizophrenic Disorders: 14</i>							(17·07%)
Paranoid schizophrenia	..	..	..	..	..	..	9
Hebephrenic schizophrenia	..	..	..	..	..	..	1
Schizoaffective illness	..	..	..	..	..	..	1
Paranoid state	..	..	..	..	..	..	2
Paraphrenia	..	..	..	..	..	..	1
<i>Affective Disorders: 23</i>							(28·04%)
Depressive illness	..	..	..	..	..	..	13
Anxiety state (with depression)	..	..	..	..	..	..	9
Hypomania	..	..	..	..	..	..	1
<i>Personality and Neurotic Disorders: 41</i>							(50%)
Abnormal Personality	..	..	..	..	..	..	15
Hysteria (sensory or motor)	..	..	..	..	..	..	13
Mixed neurosis	..	..	..	..	..	..	6
Behaviour disorders of childhood or adolescence	..	..	..	..	..	..	4
Obsessional illness	..	..	..	..	..	..	1
Psychasthenia	..	..	..	..	..	..	1
Homosexuality	..	..	..	..	..	..	1
<i>Organic Disorders: 4</i>							(4·87%)
General paralysis	..	..	..	..	..	..	1
Alcoholic hallucinosis	..	..	..	..	..	..	1
Traumatic epilepsy (with personality change)	..	..	..	..	..	..	1
Mental defect (low grade)	..	..	..	..	..	..	1

clearly incapable of understanding conversational English. Certain patients sought to escape from these hostile influences by further emigration and two wanted to return to Hungary. The majority of cases were indistinguishable in form or content from schizophrenic illnesses observed in Western countries. There was one case of schizoaffective illness who presented a particularly interesting clinical picture of paranoid illness superimposed on marked mood swings. One of the two cases described as paranoid state was suffering from delusions and a profusion of ideas of significance in a setting of severe anxiety, followed by an apparently complete recovery. The other was the passive member of a "folie a deux" partnership, the active partner suffering from paraphrenia.

An agricultural labourer, *aet.* 66, and his wife, *aet.* 51, had left their hostel after multiple scenes in which they accused the other refugees accommodated there of insulting behaviour. For several days they were roaming the streets, without adequate nourishment and sleeping in parks, until picked up by the police and admitted to an observation ward. The wife was agitated, shouting at the top of her voice; she had firmly fixed delusions about the execution of her son (he stayed in Hungary) which she believed she had witnessed in England, and her own impending execution: auditory hallucinations and ideas of reference were present. The husband appeared quiet, rather depressed, sharing the wife's delusions about the period preceding admission to hospital, but denying similar experiences since then. Neither spoke any English. They had been married for 27 years and the wife had always been known for her domineering personality.

Affective disorder was diagnosed in 23 patients. In all but one, the mood was of unpleasant quality, both anxiety and depression being present in a proportion varying from case to case. The majority of these patients described their illness in somatic terms. The climate in Britain, so different from the central European, was often blamed for these symptoms. Anxiety state was diagnosed when these complaints were mobile and of a type regarded as a physical accompaniment of anxiety. Depression was diagnosed when the

patient reported characteristic disturbances of sleep, appetite, weight or libido, or when his somatic complaints reflected his preoccupation with catastrophic illness. Separation of depressions into exogenous and endogenous seemed neither possible nor justified (Lewis, 1934; Garmany, 1958). Guilt, unworthiness or hopelessness were only rarely referred to in these terms, but the patients frequently regarded themselves as in some way responsible for their present predicament and sometimes sought a way out through self-destruction. As a whole this group showed a marked tendency to idealize the past, and this was associated with a mistrustful or resentful attitude toward the present environment. Several patients expressed regret for having left their country, a decision which they now regarded as hasty and inspired by general panic; with few exceptions, however, emigration was accepted as an irrevocable fact.

Mr. Z.H., *aet.* 24, a teacher of Russian in Hungary. Referred by B.C.A.R. Was not opposed to the régime, but let himself be persuaded into emigration by a friend. Difficulties in getting any but labouring jobs. Feels tired, tensed up. Ruminations about the future ("What will happen to me this year, next year", etc.). Blames the damp weather ("I cannot live in this country, it is affecting my soul"). Feels inadequate ("I am no good, I am very stupid and won't get anywhere"). Preoccupied with death and very apprehensive ("Everything fills me with forebodings"). He does not think that returning to Hungary or emigrating would solve his difficulties: he believes in fact that there is no remedy for them. Disturbed sleep with early waking. Loss of libido. Often weeps spontaneously.

Exactly half of our patients were diagnosed Personality and Neurotic disorders (Mayer-Gross, Slater and Roth, 1954). In this group the most frequently observed form was behavioural abnormality, often in the antisocial sense. Sensory and motor hysteria were seen in classical form—functional blindness, aphonia, paralysis, fits—much more commonly than in the local population. These "conversion" symptoms were particularly frequent in patients with low intelligence.

M.F., *aet.* 23, hotel porter. Admitted to a general hospital after being found in a dazed condition in his lodgings. On admission he was conscious, with rolling eyes and hyperventilation. He complained of unbearably severe pain around the scar (an old meniscectomy) on his left knee. Two nights after admission he became uncontrollable and very noisy. He was groaning, rolling about the bed and over-breathing so much that he produced tetany. On medical and orthopaedic examination no abnormality was found to account for his symptoms, except for some tender nodules under the operation scar. Referred for psychiatric opinion.

Always a solitary boy, very attached to his mother. Poor scholar. At the time of the uprising he was serving in the Hungarian Air Force, away from home. He came abroad following the example of other soldiers, without an opportunity to consult his parents or any definite idea of what he wanted to do. Since his arrival in England as a mining recruit he felt unhappy and wanted to return home. Left miners' hostel and came to London, but received a letter from his mother strongly advising him against returning to Hungary. Three days later, onset of symptoms described. On examination he appeared to be of very low intelligence, and this was confirmed by testing (below the 25 percentile rank on the Progressive Matrices Test). No delusions or hallucinations. Poor general information. Hyperventilation during psychiatric examination, readily stopped. Two days later he declared that the pain had gone and he left the hospital against advice.

The majority of hysterical patients exhibited marked anxiety, and emotional detachment, in the sense of "belle indifférence", was observed in two patients only. The cases diagnosed as mixed neurosis generally had long-standing or recurrent difficulties with various hysterical and anxious symptoms. There was one obsessional state, one psychasthenic personality (Schneider, 1950) and one patient who wished to be treated for his homosexuality. The

patients in this category have very often expressed dissatisfaction with their life circumstances and in certain cases have adopted a demanding attitude toward the receiving country. Several took active steps for overseas migration, and a few intended to return to Hungary.

The organic group was too small for any generalization and the symptomatology of these cases appeared indistinguishable from English patients with similar diagnoses.

In the majority of cases, the assessment of the level of *intelligence* was based on clinical impression, taking into account the patient's educational and occupational record. Where low intelligence (I.Q. < 85) was suspected, confirmation was always sought by testing with the Progressive Matrices of Raven. In our group we found 14 patients of low, 54 of average and 14 of superior intelligence.

The *treatment* of these cases was on the usual lines, depending on the diagnosis. Nearly half of the patients were admitted to hospital at some stage of their illness: 31.6 per cent. to mental hospitals (or observation wards) and 14.6 per cent. were referred for psychiatric opinion at a time when they were in-patients in a general hospital. A small proportion of the other cases were seen for a single diagnostic interview, and the majority were treated for varying periods as out-patients. It is not possible to make any general statement about course and prognosis, as many cases are too recent and systematic follow-up was not carried out. At least three of the schizophrenic patients have failed to respond to treatment, or have soon relapsed, and are in danger of becoming chronic cases.

DISCUSSION

In respect of their mode of arrival in this country and their age distribution, the composition of the group of Hungarian patients here reviewed was roughly comparable to the pool of Hungarian refugees admitted to Britain since the Hungarian uprising of October 1956. For other data (Table I) comparison with the parent population is not possible as relevant figures have not yet been published, but their distribution with regard to religion, education and social class is probably similar. The incidence of broken marriages was four and one-half times higher than in non-Hungarian patients seen at the same hospital (Blacker, 1958).

The mental hospital admission rate for schizophrenic disorders is very considerably higher in immigrants than in the native population (Ødegaard, 1932; Murphy, 1955; Malzberg and Lee, 1956). A more discretely raised admission rate of immigrants has been reported for depression (Roberts and Myers, 1954; Murphy, 1955) and for organic psychiatric illness (Ødegaard, 1932; Roberts and Myers, 1954). The method of this investigation precludes any quantitative estimate of inception or prevalence rates of mental illness among Hungarian refugees in Britain.

The history of certain or probable previous mental illness in fifty per cent of our cases is similar to the 45 per cent. reported by Pfister (1955) for refugees suffering from endogenous psychoses. A disproportionately high suicide rate among refugees has been repeatedly observed (Ruesch, Jacobson and Loeb, 1948; Murphy, 1955; Pfister, 1955). Two of our patients have made very determined but unsuccessful suicidal attempts.

The frequent initial somatic presentation of mental disorder in our patients

was probably culturally determined in the sense that illness was acceptable—and compatible with self-esteem—only if it occurred in the physical sphere. The language barrier, forcing designation of the complaint in concrete terms and in accordance with the patient's conception of the doctor's role, may well have been a contributory factor. The process is probably part of the "universal tendency for somatic representation of experience, converting it into action" (Lewis, 1956).

Paranoid states have been described in people finding themselves in total linguistic isolation, resolving spontaneously when verbal communication is again established. In view of the peculiar position of the Hungarian language, it may be more than a coincidence that several of the originally described cases were Hungarian speaking (Allers, 1920; Herschmann, 1921; Knigge, 1935). No such case has been observed in this series, but one patient presented a clinical picture and course similar to the closely related "primary paranoid state" (Schneider, 1930; Kino, 1951). These are characterized by strong emotional upset, florid delusions and rapid recovery, in people travelling through linguistically alien territory. Reasoning on psychological lines, the social and linguistic isolation of these Hungarian refugees would seem eminently favourable to the development of paranoid thinking (Cameron and Margaret, 1951). These probably facilitate normal projective mechanisms (Mayer-Gross, 1950) and thus could help to bring about the "paranoid" atmosphere of refugee camps (Penrose, 1952). Whether they could create, *de novo* as it were, a true paranoid delusion seems much more doubtful. In the majority of our schizophrenic patients this mechanism did not appear to play an important part, and the examination of their life history prior to emigration showed a distinctive pattern indicating an association between migratory record and this form of mental illness (Mezey, 1959).

The majority of cases diagnosed as abnormal, or psychopathic, personalities, were referred in the first six months following the arrival of the refugees to Britain, during a period when they were mostly living in hostels, often hastily improvised for this purpose. It was only to be expected that those whose social adaptation was at best fragile, should show various signs of disordered behaviour and cause further difficulties. Hysterical cases were relatively numerous; motor and sensory symptoms were seen in typical form and with a frequency not commonly met at present in British patients. This is in accordance with Eitinger's (1958) experience; he reported conversion symptoms in nearly half the psychiatric cases among refugees in Norway. The high incidence of this form of mental disorder is probably culturally determined (Harvey, 1956; Wittkower and Fried, 1958). Many of our hysterical patients had other neurotic symptoms as well and the choice of the exact diagnostic subgroup often proved an arbitrary decision. This can be related to war-time military practice, when a combination of anxiety and hysterical symptoms was seen much more frequently than either in isolation (Mayer-Gross, Slater and Roth, 1954).

SUMMARY

Clinical observations in 82 consecutive cases of psychiatric disorder in Hungarian refugees seen at the Maudsley Hospital during a two-year period are reported. The symptoms, diagnosis and treatment of these cases is described and the psychopathology discussed.

ACKNOWLEDGMENTS

I am indebted to Dr. D. L. Davies, Dean of the Institute of Psychiatry, who has made this investigation possible at the Maudsley Hospital. I should also like to thank Mr. E. Heimler, of the Middlesex County Council, Mr. E. Myers, of the Maudsley Hospital, Miss E. Pilbrow, of the British Council for Aid to Refugees, and Mrs. B. Soldi, of the National Association for Mental Health, for psychiatric social work with these patients, and Mrs. T. A. Maxwell for secretarial assistance.

REFERENCES

1. ALLERS, R., *Zschr. ges. Neurol. Psych.*, 1920, **60**, 281.
2. BLACKER, C. P., *Lancet*, 1958, *i*, 578.
3. CAMERON, N., and MARGARET, A., "Development of paranoid disorder", in *Behaviour Pathology*, 1951, **40**, 5. Cambridge, Mass.
4. DORMANDY, T. L., ELTON, W., and MILNER, C. A., *Lancet*, 1957, *i*, 1183.
5. EITINGER, L., *Psykiatriske Undersøkelser Blant Flyktninger I Norge*, 1958. Oslo: Universitetsforlaget.
6. FROST, I., *J. Ment. Sci.*, 1938, **84**, 801.
7. GARMANY, G., *Brit. Med. J.*, 1958, *ii*, 341.
8. HARVEY, W. A., *Int. J. Soc. Psych.*, 1956, **2**, 165.
9. HERSCHMANN, H., *Zschr. ges. Psych. u. Neurol.*, 1921, **66**, 346.
10. HOFF, H., and STROTZKA, H., *Die psychologische Betreuung ungarischer Neuflüchtlinge in Oesterreich 1956-58*, 1958. Vienna: Brüder Hollinek.
11. KINO, F. F., *J. Ment. Sci.*, 1951, **97**, 589.
12. KNIGGE, F., *Zschr. ges. Neurol. Psych.*, 1935, **153**, 622.
13. KORANYI, E. K., KERENYI, A., and SARWER-FONER, G. J., *Med. Services J. Canada*, 1958, **14**, 383.
14. LEWIS, A. J., *J. Ment. Sci.*, 1934, **80**, 277.
15. *Idem*, "Psychological Medicine", in *Price's Textbook of the Practice of Medicine*, 1956. Oxford University Press.
16. MALZBERG, B., *Social and Biological Aspects of Mental Disease*, 1940. Utica.
17. *Idem*, and LEE, E. S., *Migration and Mental Disease*, 1956. New York: Social Science Research Council.
18. MAYER-GROSS, W., "Psychopathology of Delusions", in *Congrès International de Psychiatrie*, I, 59. Paris: Hermann & Cie.
19. *Idem*, SLATER, E., and ROTH, M., *Clinical Psychiatry*, 1954. London: Cassell.
20. MEZEY, A. G., *J. Ment. Sci.*, 1960, **106**, 618.
21. MURPHY, H. B. M., *Bull. World Fed. Ment. Health*, 1952, **4**, 198.
22. *Idem*, *Flight and Resettlement*, 1955. Geneva: Unesco.
23. ØDEGAARD, Ø., *Acta Psychiat. et Neurol.*, 1932, Suppl. 4.
24. PENROSE, L. S., *On the Objective Study of Crowd Behaviour*, 1952. London: H. K. Lewis and Co.
25. PFISTER-AMENDE, M., in Murphy's *Flight and Resettlement*, 1955. Geneva: Unesco.
26. REES, E., "Century of the Homeless Man" in *International Conciliation*, 1957, No. 515. New York: Columbia University Press.
27. Refugees in Britain, *Political and Economic Planning*, 1958, **24**, 18.
28. ROBERTS, B. H., and MYERS, J. K., *Amer. J. Psychiat.*, 1954, **110**, 759.
29. RUESCH, J., JACOBSON, A., and LOEB, M. B., *Psych. Monographs*, 1948, **62**, 292.
30. SCHNEIDER, K., *Zschr. ges. Neurol. Psych.*, 1930, **127**, 725.
31. *Idem*, *Die Psychopathischen Persönlichkeiten*, 1950, 9th edition. Vienna: Deuticke.
32. TYHURST, L., *Amer. J. Psychiat.*, 1951, **107**, 561.
33. WITTOWER, E. D., and FRIED, J., *Int. J. Soc. Psych.*, 1958, **3**, 245.
34. *The Hungarian Revolution of October, 1956*, 1958. New York: Society for the Investigation of Human Ecology. Forest Hills, L.I.